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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF1 Spain**  **May 2018** |
| Job role | Vice Director |
| Organisation | Fertility Clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| **Interview summary** | Works in a medium-sized private fertility clinic.  The clinic tend to work with fresh cycles, and recruit through social media only, whilst it uses egg banks or intermediaries very rarely. Egg donation represents about 30 per cent of their overall cycles and counting.  Economic compensation is clearly singled out as the main motivation for donors, pure altruism is rather considered anecdotic. Give 50 euros extras to donors that bring in donors friends.  Suggest other clinics pay the donors more than established by the rules, and complain about tight competition. Suggests that some clinics also bring in donors from outside Spain.  Tend to fertilize all the eggs retrieved and freeze embryos instead, and only use vitrification when there is an issue with time synchronization. They inform donors about the risks of direct to consumer genetic testing, warning them to avoid these tests, if they want to keep their donation really anonymous.  Offer psychological support, control echography and free gynecological check for up to a year after donation, but note very few donors actually come along. Suggests that there has been a shift in the profile of donors through the crisis with fewer students and more workingwomen or mothers stepping forward for economic reasons.  Consider surplus eggs could (should) be frozen and stored for the donors or donated to public banks; used for other women but not sold away to other clinics inside or outside the country. Eggs should not be used for mothers older than 50 and donors should not be given extra money if their eggs serve more than one cycle.  In regards to reflections on current policy - Suggests the urgency of setting up the Registry, propose contacting and informing pediatricians and suggest rising donor minimum age to 21. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF2 Spain**  **May 2018** |
| Job role | Clinician |
| Organisation | Fertility Clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| **Interview summary** | Works in a medium-sized private fertility clinic.  The clinic has a community manager and tends to recruit mainly through social media, whilst it uses egg banks (and sperm banks) but do not speak of intermediaries. Admits they use advertisements occasionally.  Consider egg donation an outcome of the advanced maternal age and suggest egg donation is 30 per cent of their overall cycles and counting.  Economic compensation is clearly singled out as the main motivation for donors, but consider that altruism is also important. Give some extras to donors in their second or third donation cycle. Have a preference for students or for donors with at least an average educational level. Suggest that actually only about 15 per cent of women come to the second interview after get initial information.  Suggest that 1000 euros is sufficient to attract donors to come forward but fear that clinics around them offer more money. Suggest that there has been a shift in the profile of donors through the crisis with older women and more mothers stepping forward for economic reasons.  Their clinic implements a variety of medical checks in donors and also offers a genetic matching test to check genetic compatibility with prospective father or sperm donor. Suggests there are a number of risks other than hyper stimulation, but these are rare - ovary bleeding, ovary torsion and the risk of removing an ovary altogether.  Agrees that surplus eggs could be used for other women (in the same clinic) but not sold away to other clinics inside or outside the country. Believes that eggs should not be used for mothers older than 50 and donors should not be given extra money if their eggs serve more than one cycle. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF3 Spain**  **May 2018** |
| Job role | Director |
| Organisation | Fertility Clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| **Interview summary** | Works in a medium-sized private fertility clinic.  The clinic is especially active in egg donation, and has been offering this technique since the early 90s. Egg donation represents 70 per cent of its overall activities, and work equally with fresh and frozen eggs. They export part of their surplus eggs to Italy and Switzerland.  The clinic tends to recruit mainly through word-of-mouth, but also relies on social media, and intermediaries, but only to complement the donor profiles already existing in their portfolio.  They consider that the economic compensation is fair considering the effort and time offered by the donors.  They implement a variety of medical checks in donors and also offers a genetic matching test to check genetic compatibility with prospective father or sperm donor. To date, however, only between 30 to 50 per cent of the recipients ask for it, because it is expensive and of limited utility. The results of the medical and genetic tests are usually shared with the donors but only if the latter agree to have the results disclosed.  They suggest that the main cause for rejecting candidate donors is the psychological check: they admit it is difficult to find candidate donors that are responsible and committed.  Suggest that there has been a shift in the profile of donors through the crisis with more Spanish women stepping forward after and during the economic crisis. No change with economic recuperation.  Offer psychological support, control ecography and free gynecological check for up to a year after donation, but note very few donors actually take this up. The first week check they offer, however, is more popular among donors. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF4 Spain**  **May 2018** |
| Job role | Psychologist |
| Organisation | Fertility Clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| **Interview summary** | Works in a medium-sized private fertility clinic.  The interviewee addresses her role in the clinic, and emphasizes her activity as both egg donor recruiter and psychologist.  Specified the psychological criteria adopted to screen potential donors: Suicidal traits, drug consumption, low educational level, eating disorders and clear economic necessity (poverty). She emphasizes that the clinic does not accept potential donors unless they clearly have an altruistic motivation, because they need to be “free from economic pressure”. The ideal donor, thus, is a responsible, healthy, altruistic woman who takes care of herself and is socially integrated.  She considers that the main motivation of the donors is to help other women, as a result of exposure to infertility problems in their social environment; she also adds that candidate step forward for “curiosity”. However, later on in the interview, she admits that the economic compensation is a key motivator for some women.  Suggests that donors never come back to the clinic for further medical checks or psychological help after donating.  Suggest that there has been a shift in the profile of donors through the crisis with more foreign women stepping forward after and during the economic crisis and more working women, especially young mothers.  Suggests that anonymity plus economic compensation is what really motivate donors. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF5 Spain**  **May 2018** |
| Job role | Nurse |
| Organisation | Fertility Clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| **Interview summary** | Works in a medium-sized private fertility clinic.  Considered herself to be the professional that spends most time with donors and who takes care of them across all the steps of the process. Also specifies that the nurses operate first screening of the donors, before actually handing them over to the doctor and to the psychologist.  She suggests that the donor profile has not changed much across the last ten years, although she considers that younger women step forward, mostly women with temporary jobs. Some of them are young mothers, many others are students. The majority of the donors are Spanish nationals or women from Latin America, only a few from Eastern Europe.  She considers her role as a nurse to be one that has closer relationship with the donors, and someone to whom donors confess or share doubts, questions, emotions and personal information. The main fears of the donors are either that donation may reduce their chances of having a baby later on in life, or the medical process implies. She affirms that they never talk about economic compensation with donors.  Occasionally, she admits, donors had to be transferred to a public hospital because of their health status. It is quite uncommon but has happened.  It is not uncommon also that donors quit the treatment and simply do not show up again.  Considers that current regulations are good and effective, even though they might lag behind medical innovation. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF6 Spain**  **May 2018** |
| Job role | Psychologist |
| Organisation | Fertility Clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| **Interview summary** | Works in a large private fertility clinic.  Confirms that word of mouth and social media are not sufficient, and that ads and recruitment campaigns are necessary to mobilize enough donors.  She also suggests that the psychologist is the third step, in the recruitment process, after the nurse and gynecologist. She refers to two mains psychological tests used, the CIE 10 and the DSM 5. They also complement these tests with semi-structured interviews.  The main psychological disorders that screen out donors are associated with autism, schizophrenia, bipolar personality, aggressive behavior and impulsivity, but also antisocial disorders, hygiene carelessness, promiscuity and prostitution, hyperactivity etc. These disorders are also a reason to screen out if detected in the family.  Additionally, drugs and alcohol are also good grounds to reject a donor, however she suggests that as a result of their strict approach the general psycho-social profiles of the donors has improved in the past decade. Yet, still nearly 40 per cent are screened out on this basis.  The interviewee suggest that the large majority of donors come forward for the economic compensation, without knowing much about infertility and that learn to appreciate the social importance of their donation act only through the very process of donating. Some donors come forward to “repair” their conscience after an early abortion.  In some cases, donors’ parents have come forward to complain about their daughters donating, but only very rarely.  Some donors have also contacted the psychologist to get support and counseling to get on with their life after donation, however not many. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF7 Spain**  **May 2018** |
| Job role | Nurse |
| Organisation | Fertility Clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| **Interview summary** | Works in a large private fertility clinic.  She suggests that nurses have, by far, the closest and longest relation with donors, and are expected to explain all the process, risks, and details about donation to donors. Effectively, nurses first explain to donors all medical, legal, ethical and technical aspects of donations, including the consent for procedure.  She suggest that donors do not have a clear idea about altruist donation when they get into the clinic, and it is the role of the nurses to explain to donors what it is expected from them and the “real” (i.e. altruistic) nature of providing eggs.  She suggests that a first matching screening is performed by specific software on the basis of an algorithm, but that the final decision is taken by the medical staff. Information about karyotype is delivered to donors through personal, physical mail. All the other medical information is available to donors upon request.  She suggests that more eggs than are necessary for one cycle are retrieved from donors, but that usually more than four eggs are given to a single patient per cycle. The extra eggs are frozen and priority is given to the same recipient to use them if the cycle is unsuccessful. If these are not used, they are delivered to other patients of the same network of clinics. No eggs are sold or transferred to clinics that do not belong to the network.  If extra eggs are not used in years, and the original donor is willing to use them, she is entitled to, but this is a theoretical case, that does not actually happen in practice.  States that donors do not usually ask how many eggs have been retrieved from them.  She suggests that extra eggs should be given to a public bank only if the clinic, for some reasons, cannot use them.  Believes that no extra compensation should be given to donors if extra eggs are used in other cycles, because, she argues, it is donation not an economic transaction. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF8 Spain**  **May 2018** |
| Job role | Nurse |
| Organisation | Fertility Clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| **Interview summary** | Works in a large private fertility clinic.  Egg donation represents 50 per cent of all cycles at the clinic, and this is due to foreign demand. She suggests that this is due to the fact that foreign donors go directly for egg donation, whilst locals have it as a plan B. In general, during economic crisis, there was more demand for egg donation as it is more efficient, and patients had less money to repeat cycles. Also, more national donors have stepped forward during the crisis.  Vitrification has made synchronization much easier and made the business succeed, with lower coordination costs.  She suggests that the the new Registry (SIHRA) will effectively limit donor cycles to six, which will make it very hard for the clinic not only to export eggs but actually to satisfy existing national demand.  Donors are recruited through word-of-mouth and social media, also through blogs. No campaign is necessary. Donors are compensated at the end of the process, in cash. However, if donors had medical problems and could not complete the process, they get compensation - about half of the total maximum compensation.  When they raised compensation from 950 to 1000, they had a spike in donors’ recruitment. She considers that 1000 is an appropriate compensation, and rejects the French system where compensation is connected to real costs and earning losses.  Genetic tests (karyotype) are performed by external company, and donors are informed automatically if they detect something that implies exclusion from donation program. In all other cases, donors are informed only if they ask for it. The same happens with the rest of medical information. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF9 Spain**  **May 2018** |
| Job role | Clinician |
| Organisation | Hospital |
| Public/Private/Both | Public |
| Interviewer initials | VP |
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| Interview summary | Works in a medium sized public hospital.  They only treat specific fertility pathologies (early menopause, dysfunctional ovaries or genetic pathologies), and do not serve patients with age-related fertility problems. Only perform approx. 20 cycles a year.  Do not employ cross-over anonymous donation because considers that there is a risk of either secret commercialization, or family and/or friendship related pressures they cannot control. Donors are compensated with the same amount they would get in private clinics. The costs of compensation are assumed by the public budget of the regional healthcare system. They have more money earmarked for this than the amount of donors they can recruit.  Advertisements permissions are too complicated to get, so they don’t do it, prefer word-of-mouth, or to inform students at universities through their classes. Suggest that motivation among donors is clearly economical, although some degree of altruism is also present.  When no eggs are retrieved or something goes wrong, only part of the payment is given to the donor, not the full payment.  It is easier to buy eggs from commercial banks, but is more expensive. With the same money necessary to buy one batch of eggs from banks, they can get as much as four donors. Work mostly fresh cycles (when synchronization does not work, they freeze embryos rather than eggs), and shared donation programs. Give 6-7 eggs per recipients, usually one donor serve two recipients.  She suggest that once the SIHRA is in full operation, it would be a big problem because they will have to find donors that have donated less than six times, suggesting that donors donate multiple times. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF10 Spain**  **July 2018** |
| Job role | Nurse and egg donation manager |
| Organisation | Hospital |
| Public/Private/Both | Public |
| Interviewer initials | VP |
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| Interview summary | Works in a medium sized public hospital.  The nurse emphasizes her constant connection with the donors.  Suggests that the process between first interviews and the beginning of medication is much longer in the hospital than in a private clinic, as the medical results are released only about a month after the tests.  In general, they reject very, very few donors.  The retrieval is performed with local anesthesia, rather than with general anesthesia, differently from private clinics (where is always general). The reason is the lack of specialists in sedation.  Donors usually repeat a few times, are students and/or unemployed women in need, and are, on average, 20 years old. She suggests that their main motivation is clearly the economic compensation, which is lower than in the private sector (800 Vs 1000 Euros).  No psychologist is available and no medical check is organised after the retrieval.  Donors’ medication is paid by the recipient, who gets the medication and brings it to the hospital. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF11 Spain**  **July 2018** |
| Job role | Embryologist and egg donation manager |
| Organisation | Hospital |
| Public/Private/Both | Public |
| Interviewer initials | VP |
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| Interview summary | Works in a medium sized public hospital.  This embryologist is responsible for the medical and psychological interview that takes place at the beginning of the process.  The main issue he directly points out is the issue of 6 children per donor, which he considers an obsolete limitation that should be raised to 25. He also suggests that the matching with the phenotype of the mother does not make sense in interracial couples, but still they are forced to follow this criterion by current regulations. He also complains about SIHRA, suggesting it is not going to work for the lack of sufficient professionals involved in its operation.  Takes a strong negative stance against crossover anonymous donation and believes there are external pressures on donors they cannot control. He considers that the economic compensation is a much better way to access voluntary and free from pressure donors.  He considers that intermediaries are very problematic because there is no one checking on their operation, compared to the control forced onto health institutions.  Suggests that fresh eggs should be prohibited for it always implies a 10 per cent of recipients who do not get eggs from donors, and generates a huge amount of embryos that get stored and never claimed, donated or implanted.  In regards to policy suggestions, he would limit the amount of times a donor can be stimulated to retrieve eggs, the amount of eggs can be received by a single recipient (to avoid the creation of too many embryos), and he would make genetic matching compulsory. Finally, he considers that anonymity is a key aspect of egg donation, and should be preserved at all costs, even when it is known that donors can actually be identified online thanks to direct-to-consumer genetic tests. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF12 Spain**  **July 2018** |
| Job role | Gynecologist and egg donation manager |
| Organisation | Fertility clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| Interview summary | Works in a medium sized private fertility clinic.  Egg donation is a key treatment, and is responsible for 60-70 per cent of the cycles, possibly 90 per cent of revenues.  To address recruitment problems during periods of low supply or high demand, they have hired people previously working for intermediaries to set up and manage the recruitment campaigns and the advertisement strategy of their clinic. They have used intermediaries, however, only occasionally, when really necessary, and not always with great results. The point is that intermediaries are expensive compared to what they deliver. For the same reason, they recur to external egg banks only when no other option is available.  Vitrification has improved their daily work and their business in several ways. It has increased variety and availability of eggs; it has eliminated the synchronization problem; it has allowed the emergence of new business opportunities through the egg bank; and it has improved the reliability of the supply, which cannot be guaranteed in fresh cycles.  Genetic matching is offered only on demand, genetic carrier screening is routinely carried out to all donors.  The main profile among donors is the altruist one, proceeding from medical studies or university in general, yet economically motivated donors are also a relevant minority among all donors.  They find that the main concerns of egg donors are about medical risks and future fertility issues, and the guaranteed anonymity. Mostly, they fear to be contacted in the future by potential offspring.  Donors are informed of the results of the tests in two main cases: when they find something that prevents them from donating, or when they find out a serious illness problem and/or a genetic recessive condition with high prevalence (i.e. cystic fibrosis). If donors ask for more information, they will be informed. Donors are also informed of the risks associated with donation, especially risks related to ovary torsion, risk of sedation, risks of retrieval, hemorrhage and infections.  He praises the current system for it prevents a commercial war between clinics and keeps the costs of treatments low. However, he suggests that the genetic screening should be regulated by law to avoid competition among clinics on this ground. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF13 Spain**  **July 2018** |
| Job role | Nurse |
| Organisation | Fertility clinic |
| Public/Private/Both | Private |
| Interviewer initials | VP |
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| Interview summary | Works in a medium sized private fertility clinic.  Egg donation is a key treatment, and is responsible for more than 50 per cent of the treatments. Nurses are responsible for the care and support of the donors throughout the process, and in this clinic, also play a first screening role in matching.  Suggests that there are periods in which supply and demand do not meet and force the clinic to contact intermediaries or banks. They freeze eggs only when it is clear that the donor’s profile will be requested fairly soon or is especially rare (e.g. Asian, African, Nordic donors). They also hire a third part to help with recruitment.  She confirms that donors mostly have altruistic motivations but considers that economically motivated donors are quite an important minority.  Donors are mainly concerned with the future of their fertility and how donation could affect them and also concerned about the surgical process of retrieval. There are periods in which donors are less available, like exams and summer vacations, which often generate problems because summer is generally a peak period in demand.  She praises vitrification but suggests that recipients often prefer fresh cycles, which generates a variety of problems. The clinic would rather work always with vitrified eggs, but there is still public resistance.  Donors are called one month after retrieval for a gynecological check, and they usually come, except when they are “veterans”, i.e. have donated three or more times.  In policy terms, she would like to have the role of nurse more acknowledged in the clinical practice and to have more responsibilities in the overall process, considering their professional competence and the time they spend with donors. |